blue of california

tralokinumab-ldrm (ADBRY)

Diagnosis Considered for Coverage:

- Atopic dermatitis (AD)

Coverage Criteria:

For diagnosis of moderate to severe atopic dermatitis, approve if:

INITIAL AUTHORIZATION

- Age is consistent with the FDA approved indication,
  and
- Prescribed by or in consultation with a dermatologist, allergist, or immunologist, **and**
- Diagnosis of moderate to severe atopic dermatitis with at least one of the following:
  a. Investigator's Global Assessment (IGA) score of 3-4,
  b. Eczema Area and Severity Index (EASI) score of at least 16,
  c. Body surface area (BSA) of at least 10%,
  d. Severity Scoring of Atopic Dermatitis Index (SCORAD) score of at least 25,
  and
- Inadequate response or intolerable side effect to TWO of the following, or contraindication to ALL of the following:
  - Medium, high, or very high potency topical corticosteroid or
  - Topical calcineurin inhibitor [e.g. tacrolimus (Protopic) or topical Elidel (pimecrolimus)], or
  - Phototherapy, or
  - Systemic immunomodulating agents (e.g., methotrexate, azathioprine, mycophenolate mofetil, cyclosporine),

  and
- Inadequate response or intolerable side effect with two preferred agents (e.g., Dupixent, Rinvoq), or contraindication to all preferred agents,
  and
- Not used in combination with other JAK inhibitors (e.g. Rinvoq, Cibinqo), biologic immunomodulators (e.g. Dupixent), or with other immunosuppressants (e.g. methotrexate, azathioprine, mycophenolate mofetil, cyclosporine),
  and
- Dose does not exceed FDA label maximum.

Coverage Duration: 16 weeks

REAUTHORIZATION
• Patient has clinical response, **and** • Not used in combination with other JAK inhibitors (e.g. Rinvoq, Cibinqo), biologic immunomodulators (e.g. Dupixent), or with other immunosuppressants (e.g. methotrexate, azathioprine, mycophenolate mofetil, cyclosporine), **and** • Dose does not exceed FDA label maximum. ***Coverage Duration:*** one year

Coverage Duration: See coverage criteria.

Effective: 01/03/2024

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